



**TEXAS STATE BOARD OF EXAMINERS OF
MARRIAGE AND FAMILY THERAPISTS
VERIFICATION OF LICENSURE IN OTHER JURISDICTION**

DIRECTIONS TO APPLICANT: Complete Part I and forward to the state where you hold a license to practice Marriage and Family Therapy.

PART I-TO BE COMPLETED BY THE APPLICANT

| Name of Applicant | State from which Verification Requested | License No. | Date Issued |
|-------------------|---|-------------|-------------|
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I was granted a license as described above and request that verification of that license be submitted to the Texas State Board of Examiners of Marriage and Family Therapists. You are hereby authorized to release any information in your files, favorable or otherwise, directly to this state's Marriage and Family Therapists Board.

Your early attention is appreciated.

Signature Date

PART II-TO BE COMPLETED BY THE STATE BOARD VERIFYING LICENSURE (Please complete this form and return it to the address indicated on the reverse side of this form. Attach copies of any verification of supervision or supervised experience toward LMFT licensure.)

| Name of Licensee | Licensure Level | License No. | Date Issued |
|------------------|-----------------|-------------|-------------|
| | | | |

Hours of supervision and direct supervised clinical experience required for licensure held:
 Total hours of supervision: _____ Number of hours of individual supervision: _____
 Total hours of practice: _____ Number of hours of direct clinical services: _____
 Number of hours of direct clinical services to couples and families: _____
 Other requirements: _____

Please Verify Supervision Requirements Met in Your Jurisdiction
 Supervision dates: From _____ to _____ Number of months credited _____
 Employer name: _____ Employer address: _____

 Clinical Supervisor: _____ phone number: _____
 Total hours of supervision: _____ Number of hours of individual supervision: _____
 Total hours of practice: _____ Number of hours of direct clinical services: _____
 Number of hours of direct clinical services to couples and families: _____

Please Verify Supervision Requirements Met in Your Jurisdiction
 Supervision dates: From _____ to _____ Number of months credited _____
 Employer name: _____ Employer address: _____

 Clinical Supervisor: _____ phone number: _____
 Total hours of supervision: _____ Number of hours of individual supervision: _____
 Total hours of practice: _____ Number of hours of direct clinical services: _____
 Number of hours of direct clinical services to couples and families: _____

Please Verify Supervision Requirements Met in Your Jurisdiction
 Supervision dates: From _____ to _____ Number of months credited _____
 Employer name: _____ Employer address: _____

 Clinical Supervisor: _____ phone number: _____

